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analysis to advance the health of vulnerable populations

Integrating and Coordinating Care for Dually Eligible Individuals

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UMBC

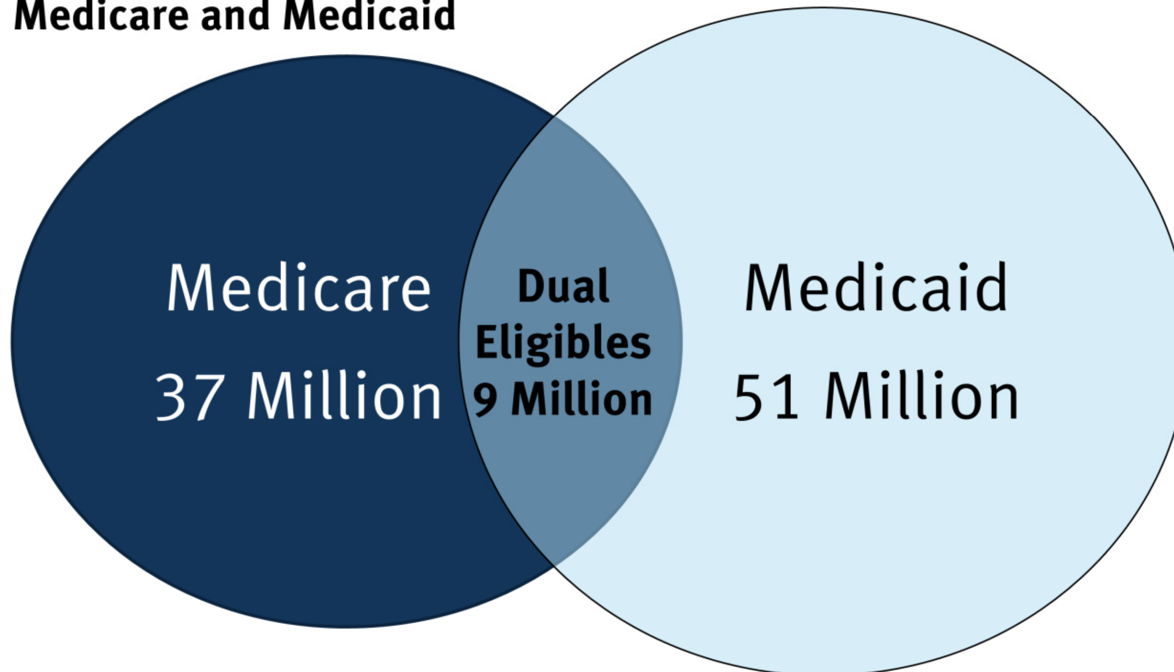
AN HONORS UNIVERSITY IN MARYLAND

Presentation Overview

- Characteristics of Medicare-Medicaid Enrollees (“Dual Eligibles”)
- Pathways to Dual eligibility
- Integrated Care: Opportunities and Challenges
- Approaches to Integrating Care
- Questions to Ask

Characteristics of Dual Eligibles

Dual eligibles comprise 20% of Medicare beneficiaries and 15% of Medicaid beneficiaries



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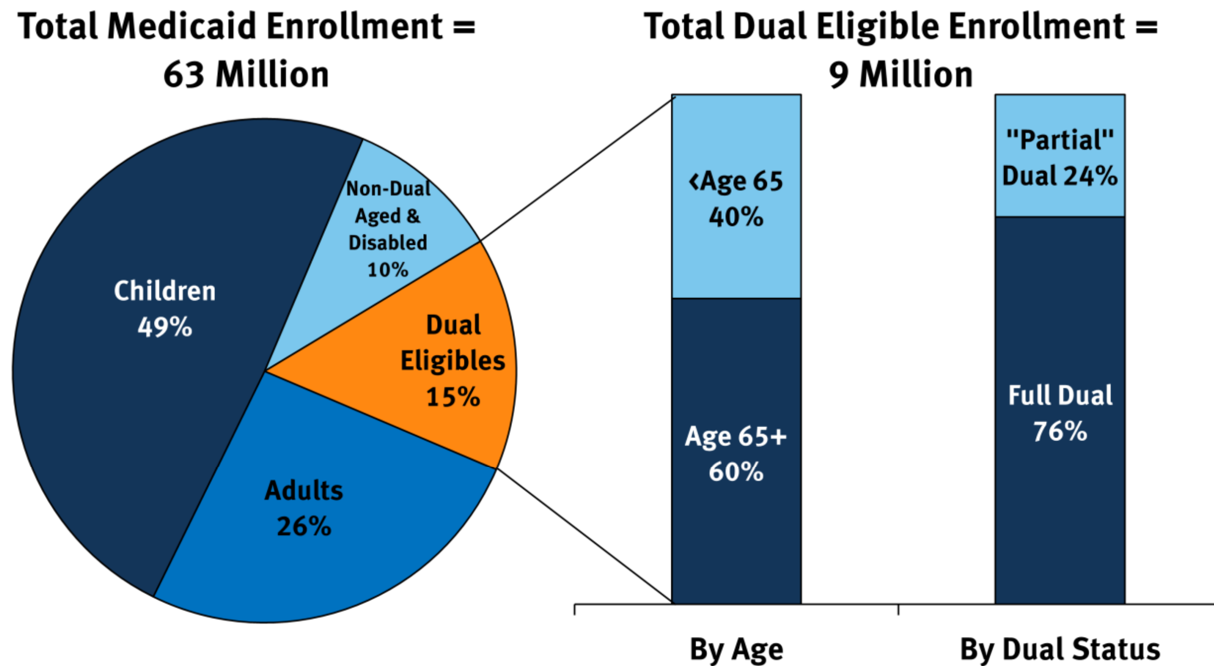
40% of dual eligibles are under age 65

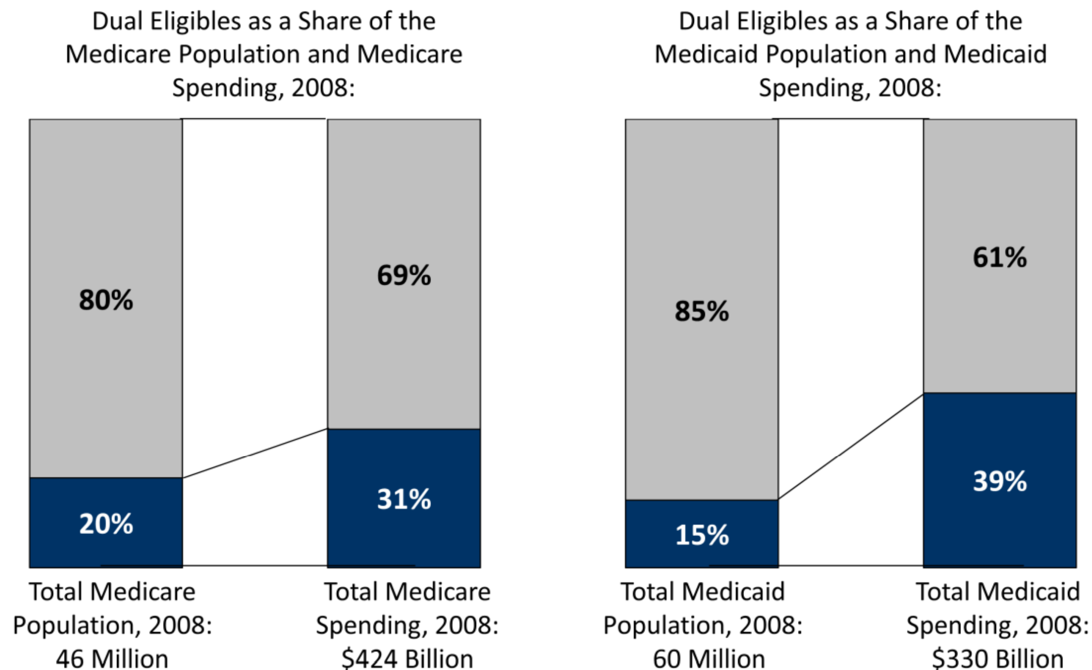
Enrollment of Dual Eligible Beneficiaries, FFY 2009



SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. 2008 MSIS data was used for PA, UT, and WI, because 2009 data were unavailable.

Dual eligibles comprise 15% of Medicaid population but are responsible for 39% of spending

Dual eligible beneficiaries as a share of Medicare and Medicaid population and spending, 2008



SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2008, and Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY2008 MSIS and CMS Form-64.

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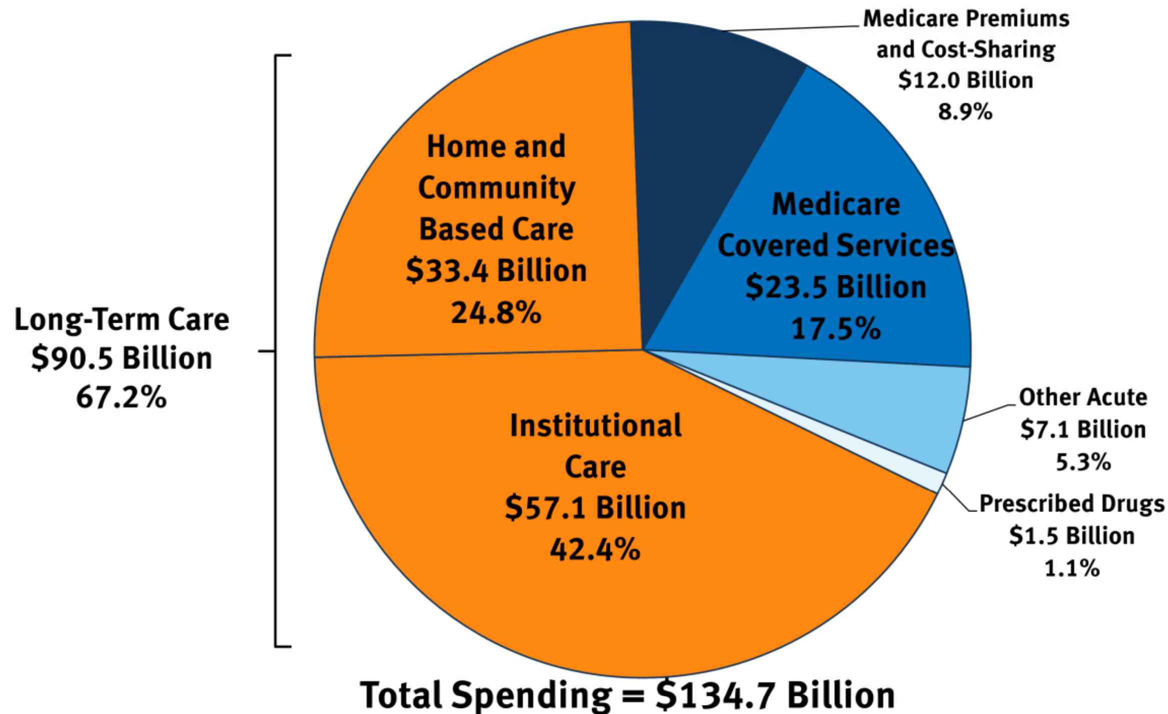
Medicaid long-term care expenditures for dual eligibles totaled $90.5 billion in 2009



Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2009 MSIS and CMS-64 reports. 2008 MSIS data was used for PA, UT, and WI, because 2009 data were unavailable.

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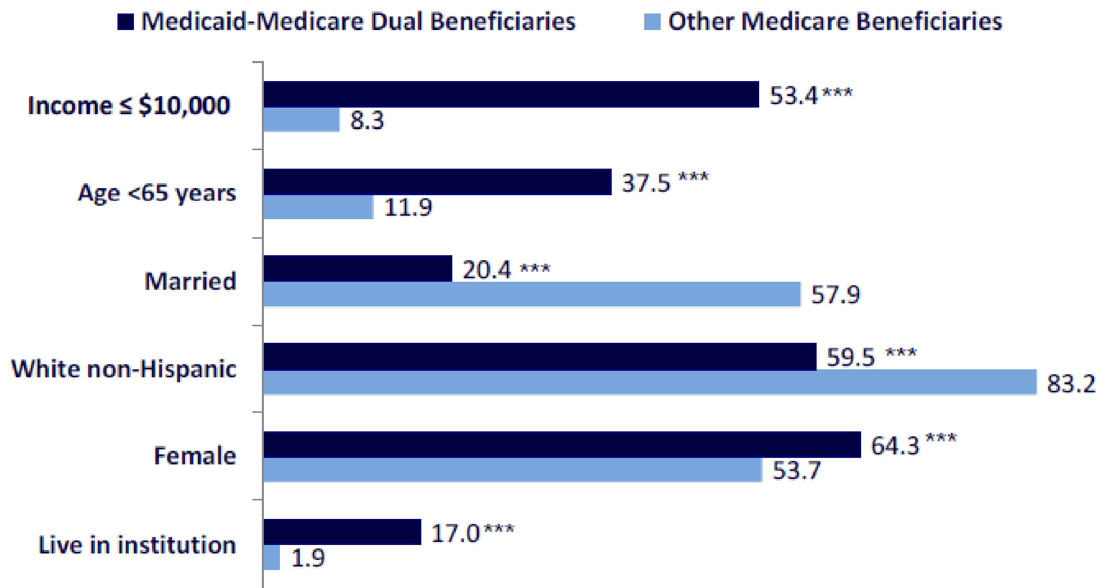
Dual eligibles tend to be younger, poorer, and more isolated than other Medicare beneficiaries



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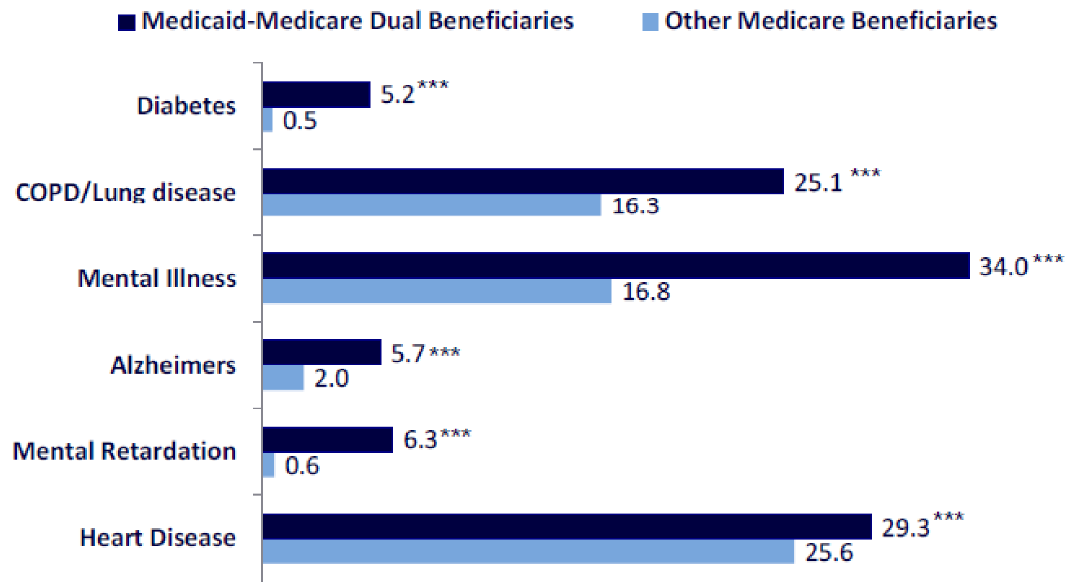
Dual eligibles are more likely to have chronic conditions than other Medicare beneficiaries



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Pathways to Dual Eligibility

Background: Social Security Disability Insurance (SSDI)

- Social Security Act, Title II
- Pathway to Medicare coverage for individuals under age 65 (generally after 24 months)

SSDI continued

- To qualify on the basis of disability:
  - Insured worker with disability who is under full retirement age (<65)
  - Individual with a disability since childhood who is a dependent of a parent entitled to Title II disability or dependent of a deceased insured parent
  - Widow/widower aged 50-60 with a disability if deceased spouse was insured under Social Security

The law defines disability as:

- Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s):
  - that can be expected to result in death, or
  - that has lasted or can be expected to last for a continuous period of not less than 12 months

Top Seven Diagnostic Groups for SSDI Beneficiaries in 2009

Diagnostic Group	Rank	% of Total
Mental Disorders—Other	1	27.5%
Musculoskeletal System and Connective Tissue	2	24.9%
Nervous System and Sense Organs	3	9.4%
Mental Disorders—Retardation	4	8.9%
Circulatory System	5	7.9%
Injuries	6	3.9%
Endocrine, Nutritional, and Metabolic Diseases	7	3.3%

Source: Social Security Administration. Annual Statistical Report on the Social Security Disability Insurance Program, 2009.

Background: Supplemental Security Income (SSI)

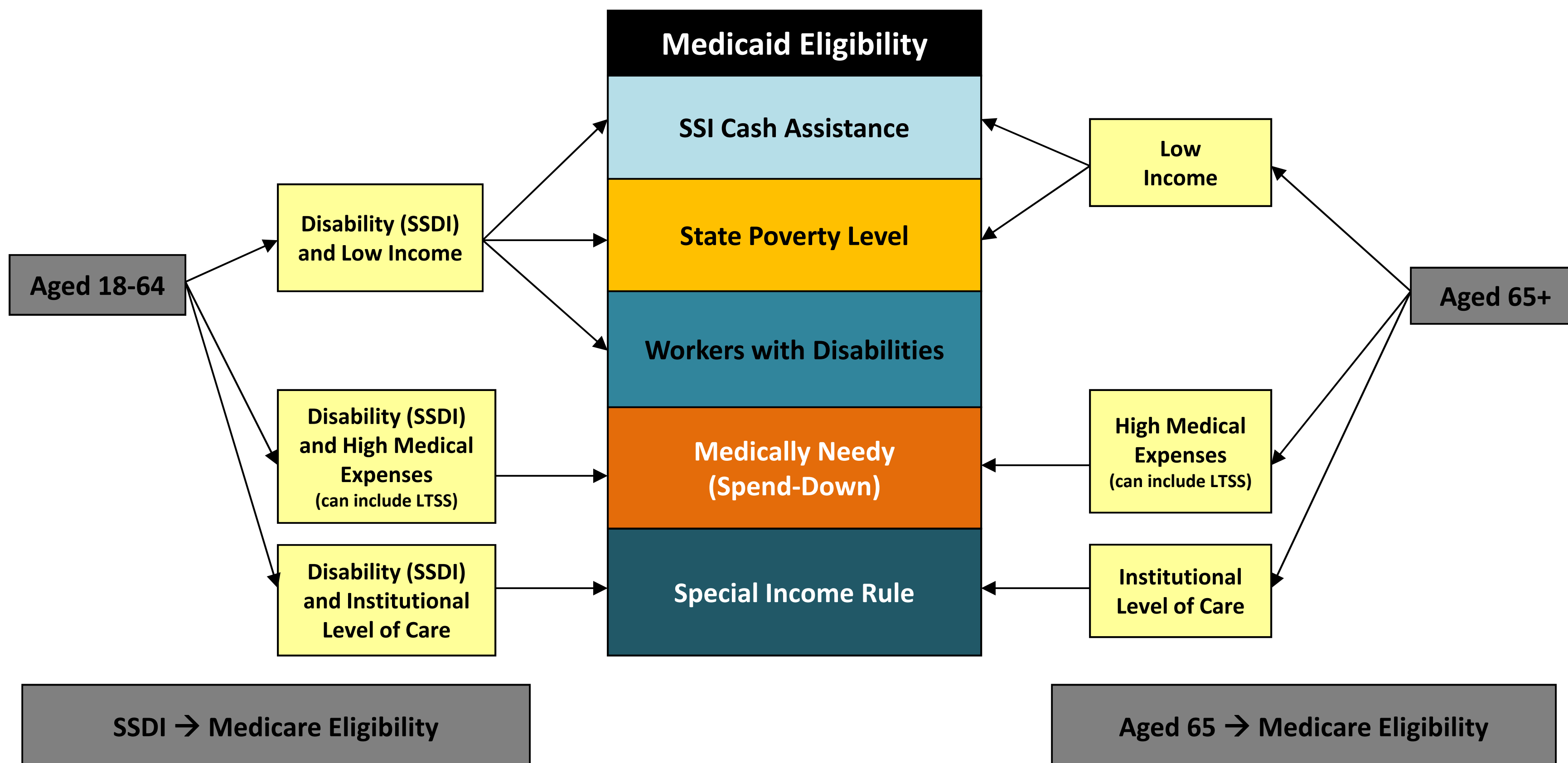
- Social Security Act, Title XVI
- Provides stipends to persons with low income who also have disabilities, who are blind, or who are aged 65 and older
- 39 states and D.C. provide Medicaid coverage to SSI eligibles; 11 states have more restrictive standards

Top Eight Diagnostic Groups for SSI Beneficiaries in 2009

Diagnostic Group	Rank	% of Total
Mental Disorders—Other	1	38.1%
Mental Disorders—Retardation	2	20.7%
Musculoskeletal System and Connective Tissue	3	11.3%
Nervous System and Sense Organs	4	7.8%
Circulatory System	5	4.2%
Unknown	6	3.8%
Endocrine, Nutritional, and Metabolic Diseases	7	3.0%
Injuries	8	2.6%

Source: Social Security Administration. Annual Statistical Report on the Supplemental Security Income Program, 2009.

Pathways to Medicare-Medicaid Eligibility



SSI Cash Assistance	State Poverty Level	Workers with Disabilities	Medically Needy	Special Income Rule
Income payment standard is generally $674 for individuals and $1,011 for couples living alone (2009 figures).	*Up to 100% of the FPL (in 2011, $908 for individuals and $1,226 for couples). 21 states and DC participate; income limits vary.*	*Income requirements vary by state. Various eligibility pathways based on earnings.*	*35 states and DC allow persons with high medical expenses to "spend down" to Medicaid eligibility. 29 states and DC also include persons in nursing homes or HCBS waivers. Not all states have HCBS waivers for persons with disabilities aged 18-64.*	*39 states and DC apply this rule, typically 300% of SSI ($2,022 in 2009), to persons in nursing homes or assessed at an institutional level of care. 21 of these states use only the special income rules.*

Source: The Hilltop Institute, 2011.

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Integrated Care: Opportunities and Challenges

What is meant by "integrated care?"

- A program that coordinates the full range of medical, behavioral health, and long-term services and supports for individuals who are dually eligible for Medicare and Medicaid
- Key to a fully integrated program is combining Medicare and Medicaid funding streams

Medicare administrators assert that there is Medicaid cost shifting to Medicare …

- Medicare program administrators and the Medicare Advantage plans often assert that Medicaid fails to adequately pay nursing facilities, leading to insufficient staffing and avoidable hospitalizations paid by Medicare due to falls, pressure ulcers, and pneumonia
- Medicare administrators assert that limited oversight by Medicaid agencies of home and community-based services (HCBS) providers, and low payment rates for HCBS services, lead to avoidable use of the emergency room and inpatient hospitalizations, which are paid by Medicare

… and Medicaid administrators respond that there is Medicare cost shifting to Medicaid

- Medicaid program administrators often assert that Medicare program administrators fail to manage hospital discharges and fail to manage Medicare providers, leading to avoidable Medicaid expenses due to long nursing facility lengths of stay and unmanaged Medicaid benefits ordered by Medicare-paid physicians

- Medicaid administrators assert that overly strict Medicare utilization management inappropriately denies Medicare coverage for home health and durable medical equipment, thereby leading to cost shifting to Medicaid

The opportunity: A integrated program could improve care and outcomes

- Coordinate (Medicare) hospital discharge planning with (Medicaid) community-based supports and services to avoid unnecessary languishing in nursing facilities

- Monitor quality of care in nursing facilities to prevent falls, pressure ulcers, and other causes of avoidable hospitalizations

- Coordinate Medicare home health, physician, and Rx services with Medicaid attendant care, transportation, and HCBS waiver services for a well-designed community-based plan of care

To summarize … What are the potential benefits of integration?

- Strong patient-centered primary care
- Multidisciplinary care team
- Comprehensive provider network
- Robust data-sharing and communications
- Consumer protections
- Financial alignment

Source: Center for Health Care Strategies. (2009). *Supporting integrated care for dual eligibles*.

What are some challenges to building an integrated program?

- Medicare "freedom of choice" (SSA §1802)
- Financing model and allocation of shared savings
- Federal/state collaboration
  - Payment/delivery model development
  - Federal waiver approval process
  - Linked Medicare/Medicaid data for rate setting, care coordination, program monitoring, shared savings calculations
  - Compliance with federal waiver requirements

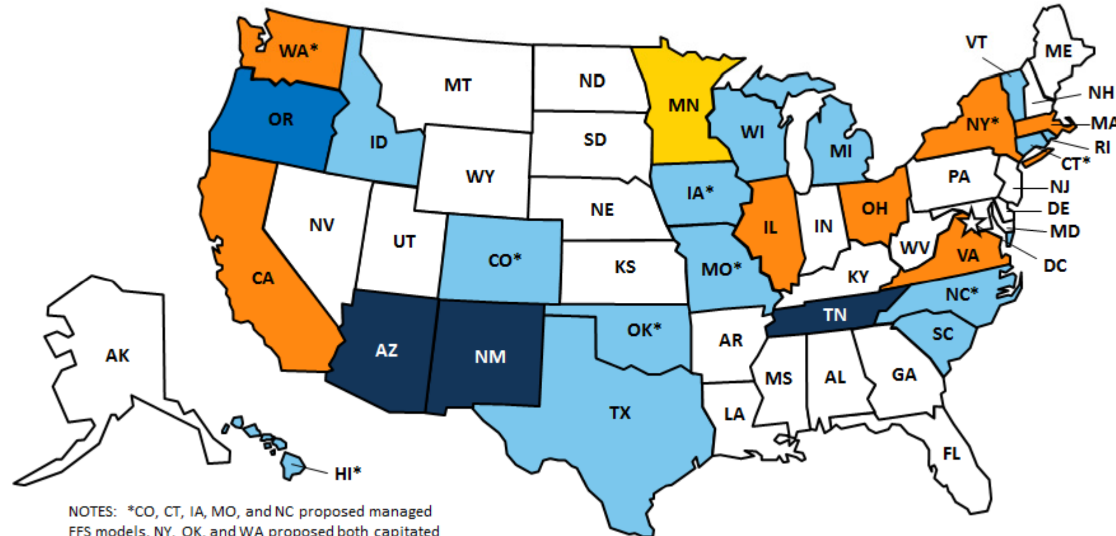
Approaches to Integrating Care

States are pursuing these strategies

- Financial Alignment Models
  - Capitated
  - Managed fee-for-service (FFS)
- Managed Long-Term Services and Supports (MLTSS)
- Health Homes and Accountable Care Organizations (ACOs)

Which states are pursuing financial alignment models?

State demonstration proposals to align financing and/or administration for dual eligible beneficiaries, September 2013



NOTES: *CO, CT, IA, MO, and NC proposed managed FFS models. NY, OK, and WA proposed both capitated and managed FFS models; NY withdrew its managed FFS proposal. All other states proposed capitated models.
SOURCE: CMS Financial Alignment Initiative, State Financial Alignment Proposals, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html, and state websites.

- MOU signed with CMS to implement financial alignment demonstration (7 states)
- MOU signed with CMS to implement administrative alignment demonstration (1 state)
- Proposal pending with CMS (14 states plus NY's DD proposal and WA's capitated proposal)
- Proposal submitted, will not pursue financial alignment but may pursue administrative alignment (1 state)
- Proposal withdrawn (3 states)
- Not participating in demonstration (24 states and DC)

Financial Alignment Models: Capitated Model

- Three-way contract between the Centers for Medicare and Medicaid Services (CMS), the state, and health plans
  - CMS and state jointly select/monitor health plans, establish payment rates (lower combined Medicare-Medicaid spending expected)
  - Prospective blended rate for primary/acute care, behavioral health, and LTSS
  - CMS and state share savings

Six states with signed MOUs:
CA, IL, MA, NY, OH, VA

Financial Alignment Models: Managed FFS

- Agreement between CMS and state, with state responsible for care coordination and delivery of integrated services
- Providers receive FFS Medicare reimbursement
- State receives retrospective performance payment for achieving targeted Medicare savings, net of any increase in Medicaid costs

One state with signed MOU for managed FFS: WA
One state with signed MOU for special demo: MN

MLTSS: What is it?

- Medicaid benefits provided through managed care
  - State pays capitated payments to managed care organizations
- Medicare benefits provided through a Medicare Advantage Special Needs Plan for dual eligibles (D-SNP) or Fully Integrated D-SNP (FIDE-SNP)
  - Medicare pays capitated payments to D-SNPs
- Care management is centralized at the health plan level using D-SNPs/FIDE-SNPs; contract with state required

16 States (7 States FIDE-SNP): AZ, CA, DE, FL, HI, MA, MI, MN, NM, NY, NC, PA, TN, TX, WI, WA

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What are the advantages of MLTSS for states?

- Flexibility
  - States can build on existing managed care and LTSS programs—e.g., 1115 and HCBS waivers
  - Can include entire LTSS population (not just duals)
  - Not limited to a 3-year demo as with financial alignment model
- Less financial risk compared to financial alignment model
  - No requirement to provide up-front savings to both CMS and the state
  - No “quality withhold” (reimbursement cuts for not achieving quality goals)

What are the challenges with MLTSS programs?

- Beneficiary must enroll with same health plan for Medicare and Medicaid benefits if care coordination across programs is going to occur
- Misalignment of processes and requirements for Medicaid and D-SNPs (e.g., marketing, enrollment, care coordination, grievances/appeals, quality)
- States do not benefit from Medicare savings resulting from efficiently delivered Medicaid LTSS
- Linking Medicare and Medicaid data for care coordination and performance monitoring is difficult

MLTSS rate setting methodology can incentivize use of community care

- MCO risk for institutional care
  - Full risk: Same capitated rate regardless of care setting
  - Partial risk: Responsibility for nursing home care limited to X days
- Reward transitions to the community (e.g., pay higher nursing home rate for 90 days after transition)

Medicaid Health Homes: A New State Plan Option

- Authorized by Affordable Care Act to serve Medicaid beneficiaries with chronic diseases
- Many states are using health homes for populations with serious mental illness (SMI)
- Many benefits to including dual eligibles (e.g., leverage assessment, care management functions, integrating behavioral health)

12 States: AL, ID, IA, ME, MO, NY, NC, OH, OR, RI, WA, WI

Medicaid Health Homes: Operational Challenges to Including Dual Eligibles

- A Medicaid program, but most medical care is provided through Medicare
- Coordinating health home with LTSS and behavioral health providers
- Access to Medicare data for care management and performance monitoring
- Financial sustainability/payment model

States are beginning to explore ACOs

- In ACOs, the payer attributes patients to providers based on historical utilization patterns
- Shared savings assessed relative to the full set of services for the covered population (some services may be carved out)
- For dual eligibles, Medicare ACOs could be extended to include Medicaid beneficiaries through a similar patient attribution method

Questions to Ask

Program Design

- Does the program design reflect the state's goals?
- Is enrollment mandatory or voluntary?
- Will consumers have a choice of health plans?
- What services are included in the design? Are there "carve outs"?
- If D-SNPs are part of the design, what is the availability of D-SNPs throughout the state?

Program Design continued

- Does the program employ a universal assessment tool?
- How will care coordination be done across care settings and payers?
- Will the program respect consumer choice/ preferences and cultural competency?
- Does the state have sufficient budget and LTSS workforce for pent-up demand ("woodwork")?

Financing

- How will financial risk be shared among CMS, the state, and the health plans?
- How will program savings be shared across Medicare and Medicaid?
- Will payment rates be risk-adjusted to reflect the acuity of different populations?
- How does the payment system incentivize health plans and providers to achieve the program's goals?

Managed Care Organizations

- Will MCOs be subject to uniform requirements for assessment, level of care determination, and care coordination?
- How will the state ensure that MCOs report “good” encounter data?

Data and IT

- Will the program have an electronic system for assessment and care management?

- Will the state be able to link Medicare and Medicaid data at the individual level for care coordination and savings calculations?

Quality Monitoring

- How will the quality of care be measured?
- How will the state and/or health plans be rewarded/penalized for meeting/not meeting quality goals?

Stakeholders

- How were stakeholders involved in program development?
- How will stakeholders continue to be involved during the implementation phase?

Program Roll-Out

- Will the program be implemented regionally or statewide?
- Will roll-out be immediate or phased in over a period of time?

Resources

- Medicare-Medicaid Enrollee State Profiles
  http://www.statedataresourcecenter.com/
- Integrated Care Resource Center
  http://www.integratedcareresourcecenter.com/

About The Hilltop Institute

The Hilltop Institute at UMBC is a non-partisan health research organization—with an expertise in Medicaid and in improving publicly financed health care systems—dedicated to advancing the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels. Hilltop is committed to addressing complex issues through informed, objective, and innovative research and analysis.

www.hilltopinstitute.org

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